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Client Information Form

Name: _____Date: _____

Telephone: _____Alt: _____
Can I leave a message? _____
Email address: _____
Address: _____
_____
_____
Date of Birth: _____
Education (grades complete, any post-secondary):
_____
_____
_____
Employment – current/
previous:_____
_____
_____
___
Emergency Contact: _____Telephone:
_____

Marital Status: _____Partner's Name:
_____
How long together? _____
Previous important relationships:
_____
_____
_____
_____

Names/Ages of Children
_____
_____
_____
_____
Who referred you or how did you find me?
_____
__
Family Doctor: _____

Significant physical health problems:

Medications:

Previous counselling experiences:

Family of origin history:

Family history of psychiatric problems (who, diagnosis/symptoms):

What do you do to have fun and relax?

Generally, how adequately do you feel you are functioning in your life right now?

_____

What issues would you like to focus on during therapy?

_____
_____
_____
_____
_____

Additional Notes:

_____
_____
_____
_____
_____
_____